November 3, 2023

Hon. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-3442-P
P.O. Box 8016
Baltimore, MD 21244-8016
http://www.regulations.gov

RE: Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting (CMS-3442-P)

Dear Ms. Brooks-LaSure:

I am writing on behalf of LeadingAge New York to comment on the CMS proposal to establish nursing home minimum staffing requirements ("the Proposed Rule"). LeadingAge NY represents over 400 not-for-profit and public providers across the entire continuum of long-term care and senior services throughout New York State, including Skilled Nursing Facilities (SNFs) and continuing care retirement communities. Our national affiliate, LeadingAge, is an association of 5,000 not-for-profit organizations providing long term care services and supports throughout the United States. LeadingAge NY endorses the separately submitted comments of LeadingAge. We appreciate the opportunity to convey our grave concerns regarding the Proposed Rule's potential impacts on quality and access to care in New York State and on the viability the state's non-profit and public nursing homes.

We share your commitment to the quality of care that residents and patients receive in all health care settings, and we recognize that quality depends significantly on the skills and dedication of direct care staff and their leaders. However, the staffing requirements in the Proposed Rule are unrealistic and discourage person-centered staffing models. Given severe staffing shortages and reimbursement shortfalls experienced by nursing homes, the requirements of the Proposed Rule will inevitably lead to fines that will only drain nursing homes of the funds they desperately need to hire and retain additional staff. Our analysis of the most recent payroll-based journal (PBJ) data supports this conclusion – not a single non-specialty nursing home in New York State met the proposed HPRD levels every day in the first quarter of 2023. As the agency charged with setting Medicare rates and approving Medicaid rates – the two principal sources of nursing home payment -- CMS bears the responsibility for ensuring that the requirements it imposes are funded, as well as feasible. The Proposed Rule is neither. Accordingly, the Proposed Rule represents a false promise to residents, their families, and staff. We urge CMS to rescind the Proposed Rule until there are sufficient numbers of nurses and aides available to meet the requirements, and Medicaid and Medicare reimbursement rates can support the staffing levels required.

We begin our comments with some general recommendations, followed by a more detailed analysis of selected aspects and impacts of the regulations and lessons from New York's nursing home staffing mandates. We conclude with some of the specific input solicited by CMS to the extent it is not incorporated in the earlier sections.

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I. GENERAL RECOMMENDATIONS

Nursing home staffing is currently subject to federal and state regulation, scrutinized by surveyors, reported through the PBJ system, and measured, publicized, and incentivized through the CMS 5 Star System and the New York State Nursing Home Quality Pool. Leveraging the existing oversight and incentive structures to monitor staffing at nursing homes is a better approach than the one-size-fits-all numerical requirements set forth in the Proposed Rule. Numerical staffing levels like those set forth in the Proposed Rule, should not be imposed unless the following key criteria are satisfied:

1. **A sufficient number of trained and licensed or certified candidates, along with the systems to continue to train the workforce needed as demand increases, must be available to meet any numerical staffing requirements.** The Proposed Rule fails to consider in a serious way where nursing homes will find the estimated 12,639 additional registered nurses (RNs) and 76,376 additional nurse aides (NAs) needed to comply with its requirements. The proposed $75 million in training funding is not nearly sufficient to develop the needed staff. Further, staffing standards must be informed by labor market dynamics, including the workforce shortages across the health care delivery system, the resulting labor market competition, and the increasing need for backfilling existing nursing home positions as aging staff retire or leave the field. This empirical analysis must take into account the geographic distribution of the staff as well as the impact of shortages in, and on, other settings that compete for the same talent.

2. **Medicaid and Medicare rates for nursing homes must be sufficient to cover current costs, as well as additional costs driven by any new staffing mandates.** Providers must be appropriately reimbursed to ensure that they have the necessary financial resources to meet any new staffing mandates. Medicare and Medicaid bear substantial responsibility for the adequacy of reimbursement to cover the costs of mandated staffing levels, as most nursing home services are paid for by these government programs. Often Medicaid and Medicare rates are inadequate to cover current costs, much less the added costs of the Proposed Rule, and rates are not structured in a way that rewards providers with higher staffing levels. Significant resources are needed to counter demographic trends and enable nursing homes to compete with other employers that have stronger revenue streams.

3. **Any staffing mandate must support person-centered, innovative staffing models and reflect the needs of residents.** Regulations that mandate the numbers of hours to be provided by staff with specific titles, while ignoring the care provided by others (e.g., therapy staff, feeding assistants, activity staff, etc.) risk undermining innovative, team-based staffing models that enhance quality care and enrich the quality of life for residents. Nursing homes should have the flexibility to engage staff with the training and certifications, and for the number of hours per resident, appropriate to the needs of their residents.

We urge CMS to rescind the Proposed Rule, unless and until such time as these three fundamental prerequisites are met. If the Proposed Rule or similar mandates are imposed without meeting these conditions, CMS's effort to promote safety, quality, and access will fail.

II. WIDESPREAD STAFFING SHORTAGES MAKE COMPLIANCE WITH THE MANDATES IMPOSSIBLE

The two key factors impacting a facility's capability to successfully recruit and retain nursing staff are the availability or lack of: (i) candidates for open positions; and (ii) adequate financial resources to compete with other employers for the limited number of candidates. Neither factor is within the control of nursing homes. In fact, the federal and state governments have a greater influence over the workforce pipeline and the funding available to compensate staff than nursing homes do.

Our not-for-profit and government-sponsored members are committed to ensuring that the residents they serve are provided the highest quality of care and quality of life possible. They struggle daily to attract and retain qualified and dedicated staff to accomplish this, despite chronic underfunding and widespread workforce shortages. They share the Biden-Harris Administration's goal of ensuring that their workforce is "supported, valued, and well-paid." Accordingly, they have pursued a variety of creative strategies in an effort to attract and retain staff. In addition to paying wages and benefits that tend to exceed regional averages, they provide financial incentives and work-related supports, such as sign-on and retention bonuses, child care assistance, flexible hours, career ladders and peer mentoring, nursing school tuition reimbursement, hazard pay, shift differentials, etc. When faced with an inability to recruit needed staff, most mission-driven providers opt to limit admissions to ensure existing staff are not overly stressed, and quality of care is maintained.

Sadly, our members' efforts to expand their staff are thwarted by the lack of candidates to fill open positions. Along with most states, New York is in a prolonged and severe staffing crisis, driven in part by demographic trends and in part by the COVID-19 pandemic. Like most states and the nation as a whole, New York has a rising population of older adults, and a shrinking portion of the population between ages 18 and 64. Between 2015 and 2040, the number of adults aged 65+ in New York will increase by 50 percent, and the number of adults over 85 will double.[1] At the same time, the percentage of the population available to care for an expanding older adult population (i.e., the working age population) is shrinking. Both informal caregivers and direct care workers in long-term care are already in short supply, and the gap will only grow. This dynamic is likely replicated in other states as well.

Recruitment and retention challenges arising out of these demographic trends have been exacerbated by the COVID-19 pandemic which took a physical and emotional toll on nursing home staff. Later, COVID vaccine hesitancy contributed to attrition and impeded hiring. New York State's Commissioner of Health determined that there was an acute labor supply shortage of nurses and aides statewide in 2022, and while the 2023 determination has not yet been issued, conditions have not improved.[2] The Bureau of Labor Statistics indicates that projected demand for healthcare workers exceeds supply across most healthcare settings, and conditions are not expected to improve in the near term.[3]

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[1] Cornell University Program on Applied Demographics New York State Population Projections; http://pad.human.cornell.edu/; accessed Jun. 1, 2022.

[2] NY Commissioner of Health, "Commissioner's Determination on Acute Labor Supply Shortage Pursuant to 10 NYCRR 415.13(f)(2)(ii)(b)(1)," June 22, 2023, accessed at https://www.health.ny.gov/facilities/nursing/minimum_staffing/docs/commissioners_determination.pdf

[3] Bureau of Labor Statistics, News Release, "Employment Projections: 2022-2032 Summary," Sep. 6, 2023, accessed at https://www.bls.gov/news.release/pdf/ecopro.pdf. The release notes that "the health care and social assistance sector is projected to add about 2.1 million jobs from 2022 to 2032, the most of any sector and about 45 percent of all new jobs."

According to our analysis of PBJ data for the first quarter (Q1) of 2023, not one of New York State's nursing homes (excluding pediatric facilities) would be able to comply with the Proposed Rule's HPRD requirements on a daily basis. Nearly 50 percent would be unable to comply with the 0.55 RN HPRD requirement, and more than 80 percent would be unable to comply with the 2.45 nurse aide (NA) HPRD requirement.

Unfortunately, we do not have the data to determine the current use of RNs on a 24/7 basis. Anecdotally, we understand from our members that the 24/7 RN requirement is particularly challenging for rural providers. These providers simply cannot find RNs to work the overnight shift. They have an RN on call who can arrive at the facility within a short time if needed, but they do not have an RN on site round-the-clock. In light of these realities, if this provision is adopted, it is critical to maintain and expand the current RN waiver process as described in Part V below.
In order to comply with the staffing levels set forth in the Proposed Rule, CMS estimates that 12,639 additional RNs and 76,376 additional NAs will be needed.[4] Most will have to be trained and licensed or certified in the next two to three years. The delayed effective dates for the 24/7 RN and the HPRD requirements do not provide enough time to enable the state and federal governments and nursing homes to build the pipeline of workers needed to fulfill the requirements. Nurses and aides cannot be developed overnight. In particular, a nursing degree requires a minimum of two years of study plus additional time to take the NCLEX exam and obtain a license. Although nursing is one of the most rapidly growing fields, nursing education programs simply cannot keep up with current demand.[5] In the absence of a significant increase in nursing school graduates, given existing shortages, nursing homes are likely to find it difficult to impossible to recruit the additional nurses that would be required by the staffing standards.

Aides can be trained more quickly, but finding and training appropriate candidates in sufficient numbers within the time allotted will be extraordinarily challenging. It will require a concerted and sustained investment of public and private resources to create the additional training and testing capacity; to find, recruit and train over 75,000 interested individuals who have the necessary literacy skills and personality traits; and to enable them to complete their training and certification within three to five years.

CMS contends in the Proposed Rule that the number of LTC facility staff has begun to rebound and that facility census has declined. However, CMS should not rely on declining census numbers to justify its numerical staffing requirements. In New York State, we have observed that low occupancy levels are not based on a lack of demand for beds, but rather on the lack of sufficient personnel to staff them and comply with state staffing mandates. Many of our members maintain waiting lists for beds and report that they have "taken beds and units offline" due to staffing concerns, including the risk of non-compliance with state mandates. In the face of reduced nursing home capacity, hospitals are clamoring for nursing homes to accept more residents in order to free up hospital beds and relieve overcrowding in emergency departments. Moreover, given demographic trends, the demand for nursing home care will only grow.

In an environment where there is not a sufficient number of candidates for nursing home jobs, hiring the additional RNs and NAs that the Proposed Rule requires is simply not possible within the time

[4] Proposed Rule, at 61377.
[5] American Association of Colleges of Nursing, Fact Sheet: Nursing Faculty Shortage, Oct. 2022, accessed at https://www.aacnnursing.org/news-data/fact-sheets/nursing-faculty-shortage .

allotted by the Proposed Rule. We understand that the Proposed Rule provides a hardship exemption from the HRPD requirements and a waiver process for the 24/7 RN requirement. However, as detailed below, the hardship exemption and the waiver process are available only under limited circumstances and provide little relief from the infeasible mandates. The inevitable fines that result will only serve to drain providers of the resources they need to recruit and retain staff.

III. INADEQUATE REIMBURSEMENT FROM GOVERNMENT PAYERS PREVENTS NURSING HOMES FROM COMPETING WITH OTHER EMPLOYERS FOR AVAILABLE STAFF

Compliance with the staffing requirements set forth in the Proposed Rule will require not only the creation of tens of thousands of nurses and aides, but also sufficient resources to pay staff competitive wages. Labor market dynamics have driven up wages across-the-board and increased opportunities for individuals to work in less demanding settings, making it harder for nursing homes to compete with other employers. Unlike hospitals and other providers, nursing homes are unable to shift costs to private payers in order to compensate staff more generously. In New York State, for example, more than 72 percent of nursing home days are reimbursed by Medicaid, and Medicare covers approximately 14 percent. Thus, only the remaining 14 percent of days (i.e., those not covered by Medicare or Medicaid) are reimbursed at rates that nursing homes have some ability to influence.

Moreover, New York State 's Medicaid rates cover only a portion of the daily cost of care, leaving approximately 25 percent of costs unreimbursed on average. Our nursing home Medicaid rates are based on 2007 costs. Not only has New York failed to raise Medicaid rates to keep up with rising labor and other costs; it actually imposed significant cuts during the pandemic. After years of stagnant rates and cuts, New York finally provided a 1 percent across-the-board increase in 2022 and a 6.5 percent increase in 2023 (a 7.5 percent increase was enacted, but CMS has not approved either a 6.5 percent or 7.5 percent increase to date). That promised 7.5 percent increase, when approved, will not even cover the increased costs associated with inflation and collective bargaining agreements reached with the largest nurse and aide unions in 2023.

The growing gap between payment rates and costs is exacerbated by workforce shortages that are forcing desperate facilities to use staffing agencies that charge exorbitant fees. This dynamic is further increasing staffing costs to unsustainable levels. There is little that individual nursing homes can do to mitigate expenses or increase revenues.

Given the heavy dependence of nursing homes on government payers, and CMS's significant role in determining Medicare rates and approving state Medicaid plans, CMS bears the responsibility for ensuring that new and costly staffing requirements are fully-funded. Nevertheless, the proposed rule fails to provide, or even to recommend, additional funding to cover the billions of dollars of additional costs associated with the requirements of the Proposed Rule.

CMS has encouraged states to use Medicaid authority to improve the safety and quality of nursing home care. However, one obstacle to the implementation of more appropriate Medicaid rates is CMS's own calculation of Medicaid upper payment limits (UPLs). If CMS refuses to allow states to raise Medicaid rates, even though the rates cover only 75 percent of the daily cost of care for each Medicaid

beneficiary (as in New York), then CMS cannot expect nursing homes to have the resources necessary to increase their staffing.[6]

Moreover, the Proposed Rule appears to grossly underestimate the additional costs it will impose on nursing homes. CMS projects that the cost of the new mandates will exceed $4.6 billion annually nationwide and $411.6 million in New York State. However, LeadingAge estimates that the annual cost of just the additional staff hours alone at the current wages would be closer to $7.2 billion nationally in the first year, and $644 million in New York State -- more than 50 percent higher over time than estimates presented in the Rule.[7] The LeadingAge estimate is based on daily hours and census, rather than the quarterly averages that CMS uses. Notably, if CMS intends to enforce the requirements on a daily basis, it must calculate costs on a daily basis too. CMS's estimate also fails to take into account the additional costs that must be incurred to retain contract staff – an unfortunate by-product of the very tight nursing labor market. Further, because of the upward pressure that would be exerted on wages from the increased competition for the required staff, the actual cost of meeting the mandates is likely even higher than our estimates suggest.[8]

Before imposing new staffing mandates, CMS should conduct a study of rate adequacy under both Medicare and Medicaid. It should adjust rates as needed to ensure that they enable nursing homes to pay competitive wages and that they cover the costs of care under the new requirements. To the extent that Medicaid UPL calculations interfere with the ability of state Medicaid programs to pay appropriate rates, CMS should reexamine how it determines UPLs and whether the methodology is valid.

IV. ARBITRARY HPRD MANDATES ARE LIKELY TO HAVE NEGATIVE IMPACTS ON ACCESS AND IMPEDE PERSON-CENTERED STAFFING MODELS

Unable to find qualified candidates in sufficient numbers or to cover the cost of competitive wages for the few who apply, nursing homes have only one available strategy to attempt to comply with "hours per resident day" requirements – reduce the number of residents. This will limit access to quality nursing homes in many communities. As described in more detail in Part VII below, in New York State, we are already experiencing constricted access to quality nursing home care in response to minimum hours requirements. And, limits on nursing home capacity is having ripple effects across the health care continuum.

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[6] *See* "Estimates of Medicaid Nursing Facility Payments Relative to Costs." Medicaid and CHIP Payment and Access Commission. Jan. 2023, available at https://www.macpac.gov/publication/estimates-of-medicaid-nursing-facility-payments-relative-to-costs/ (concluding that the average Medicaid base payment rate in 2019 was 84 percent of reported facility costs).

[7] LeadingAge cost estimates of the additional staff hours required to meet proposed requirements calculated using Q1 2023 PBJ Employee Detail data accessed at https://data.cms.gov/quality-of-care/payroll-based-journal-employee-detail-nursing-home-staffing, CMS Nursing Home Provider Information File, August 2023 accessed at https://data.cms.gov/provider-data/dataset/4pq5-n9py, and wage data from Medicare Cost Reports through 2021 accessed at https://www.cms.gov/httpswwwcmsgovresearch-statistics-data-and-systemsdownloadable-public-use-filescost-reportscost/2021-1.

[8] NY State Department of Health, "Study of Nurse Caregiver Minimum Staffing Levels and Other Staffing Enhancement Strategies and Patient Quality Improvement Initiatives," August 2020, accessed at https://www.health.ny.gov/press/reports/docs/2020-08_staffing_report.pdf. The analysis points out that staffing mandates "will drive up demand for nursing staff in ways that increase wages in those industries as well as in other related industries employing nursing staff".

Not only do the proposed staffing requirements threaten access to care, they also discourage staffing models that are tailored to the needs of residents and enhance quality care and quality of life by optimizing available staff in all titles. For example, facilities that serve significant numbers of residents with complex medical needs require different staffing models from those that serve significant numbers of ambulatory residents with dementia. Those that serve a medically-complex population will likely require more nurses, respiratory therapists, rehabilitation therapy staff, and other specialized staff. Facilities that serve greater numbers of residents with dementia who are ambulatory must offer more social activities and supervision than assistance with activities of daily living. They need additional activities staff, social workers, and companions and fewer CNAs and nurses. Nevertheless, given the limitations imposed by government rates and staffing regulations, the facility with a medically-complex population may be forced to hire more aides and sacrifice nurse coverage in order to do so. Or, it may need to deploy RNs and LPNs to work as aides in order to fulfill the specified aide hour requirement. Conversely, the facility with significant numbers of ambulatory residents with dementia may be forced to hire more aides and nurses at the expense of activities, social work and companion staff. Neither residents nor their families will support these outcomes.

The pervasive staffing shortages affecting nursing homes demand flexibility in staffing models and collaborative team-based approaches. A wide array of professionals and paraprofessionals, in addition to nurses and aides, play important roles in supporting health and quality of life of nursing home residents. These include feeding assistants, recreation therapists and activities staff, rehabilitation therapy personnel, chaplains, nurse practitioners, physician assistants, physicians, and social workers. Activities staff support the nursing staff by offering residents meaning, joy and creative outlets, while helping them to maintain cognition and physical function, reduce agitation and conflict, and improve their emotional wellbeing. Therapy staff not only provide supervised rehabilitative exercises, they also assist with activities of daily living, including eating, bathing, and dressing, in order to help residents preserve or improve their independence and prepare for discharge. The Proposed Rule does not take into account the effectiveness of interdisciplinary approaches to staffing and instead favors a more conventional paradigm. CMS should support a more resident-centered and flexible approach.

V. HARDSHIP EXEMPTIONS AND WAIVERS ARE TOO RESTRICTIVE TO ENSURE ACCESS

Given widespread workforce shortages and reimbursement that does not cover the costs of competitive wages, the hardship exemption and waiver processes are critical to preventing mandate-driven limits on nursing home access and the sweeping imposition of fines on nursing homes for conditions that are beyond their control. When imposed on facilities that are doing their best to comply with the requirements in the face of daunting market conditions or other extenuating circumstances, penalties will not benefit residents – they will only sap facilities of the resources needed to recruit and retain staff and force them to limit admissions or close entirely.

CMS states in the Proposed Rule that the goal of the hardship exemption is to balance safe and high-quality care with access to care.[9] Thus, the hardship exemption and the waiver processes should provide fair and reasonable processes for preserving access to care, while promoting improvements in staffing for facilities that are unable to comply with the requirements. The proposed hardship exemption and waiver process are too limited to have the desired effects.

[9] Proposed Rule at 61377.

As drafted in the Proposed Rule, the hardship exemption applies only to facilities: (i) in an area with low or medium provider-to-population ratios or that is 20 miles or more from the nearest LTC facility; (ii) with a demonstrated good faith effort to hire and retain nursing staff; and (iii) with a demonstrated financial commitment to staffing based on expenditures relative to revenue; and not subject to any of the exclusions. The geographical areas used to determine whether a nursing homes is experiencing a shortage of nursing staff is the metropolitan statistical area (MSA) or non-MSA where the LTC facility is located. The MSA is not an appropriate geographic delineation for this purpose.

MSAs can be large geographic areas that comprise rural, suburban and urban communities with varying population densities, disparate levels of access to public transportation, and even widely divergent types of roadways and geographic features that impact commuting time. For example, the Rochester MSA includes Livingston, Monroe, Ontario, Orleans, Wayne, and Yates counties. While the area in and around Rochester is densely populated and urban or suburban, the remaining areas of the MSA are largely rural. To expect aides to commute from Rochester and its suburbs to nursing homes in Mount Morris or Penn Yann is unreasonable. Similarly, the Albany-Schenectady-Troy MSA covers the urban centers reflected in its name as well as the "hill towns" of Albany County, the foothills of the Adirondacks and horse farms in Saratoga County, and the agricultural communities of Schoharie County (population density of 51 people per square mile). Again, it would be very difficult for aides in Albany, Schenectady or Troy, to commute to a nursing home in Saratoga Springs or vice versa. Measuring provider-to-population ratios based on such large and diverse geographic regions does not make sense. The average ratio across the region may be irrelevant to workforce availability in specific communities.

Furthermore, the exemption criteria should consider not only the existence of a low provider-to-population ratio or remoteness from the nearest LTC facility, but also competition for nursing staff in the region. Thus, a facility should be eligible for a hardship exemption even if it does not have a medium or low provider-to-population ratio as defined in the Proposed Rule or if it is located near another LTC facility, provided that it is located in a region with a great deal of competition for nursing staff. For example, if there is a relatively high concentration of hospitals, physician practices, and/or other health or long-term care facilities in the region compared to working age population, a facility should be able to qualify for an exemption. Similarly, having two or more LTC facilities within 20 miles of each other may create sufficient competition for a limited pool of staff to impede compliance with the staffing standards at one or both facilities.

While well-intentioned, the financial commitment criterion is redundant, ill-defined, and likely to have unintended consequences. The appropriateness of spending on direct care staff will be considered as part of the good faith effort criterion. A vague reference to staffing expenditures relative to revenue may discourage or devalue other spending that is important to the quality of care and quality of life of residents, such as capital investments that create a homelike environment or strengthen the infection prevention posture of the physical environment. We recommend that CMS eliminate the financial commitment criterion.

In response to CMS's inquiry regarding other hardships that would justify exemptions, we recommend adding extenuating circumstances beyond the facility's control, such as weather emergencies. Heavy snow and flooding can impede the ability of staff to travel to work. Nursing homes activate their emergency plans when these situations arise, and make every effort to staff appropriately, but they should not be penalized if they fall short by a fraction of an HPRD for a few days. Exemptions such as these would prevent the unfair imposition of penalties that would only deprive facilities of resources needed for resident care.

Like the exemption criteria, the criteria for waivers of the 24/7 RN requirement under 42 C.F.R. §483.35(f) are inadequate to ensure access to care. Waivers are more limited than exemptions in that they are available only to facilities in rural areas. They are not available to facilities in non-rural areas where there are simply insufficient numbers of RNs willing to work all shifts. The waiver of 24/7 RN coverage should be available not only in rural areas, but also in areas that are underserved or that have substantial competition for nurses.

Finally, we urge CMS to make the waiver and exemption processes transparent to the public. The standards implemented to authorize waivers and exemptions, the number of waivers and exemptions granted or denied, and the bases for these determinations should be made available.

VI. MINIMUM HPRD REQUIREMENTS SHOULD INCLUDE LPN/LVN HOURS IN THE NURSE OR NA HPRD

The Proposed Rule, unlike New York State's staffing mandates, does not recognize the important role played by LPNs in nursing home staffing. Under the direction of an RN, LPNs may administer medications, provide nursing treatments, collect specimens, administer vaccines, place IV's, draw blood, insert/change foley catheters, perform ostomy and wound care, and gather measurements, signs, and symptoms. They also oversee the NAs to ensure that care plans are followed. They provide an intermediate and necessary level of care between RNs and NAs, enabling RNs to focus on higher level care responsibilities. Because our state does not recognize "medication aides" or similarly trained advanced NAs, only nurses may pass medications. As a result, our nursing homes rely heavily on LPNs to distribute medications, among other responsibilities. Of the 1.2 HPRD of licensed nursing care provided to nursing home residents in New York State in Q1 of 2023, 0.71 HPRD was delivered by LPNs on average.

Under the Proposed Rule, LPNs will not be counted at all. This will disadvantage nursing homes in states like New York, where medication aides are not authorized. In order to meet staffing mandates, New York nursing homes may be required to assign RNs to administer medications, diverting them from higher level tasks. They may also have to assign LPNs/LVNs to NA roles to meet NA HPRD requirements. Given the gap between government rates and costs, homes may have to lay-off LPNs/LVNs to help cover the costs of additional RNs and NAs. None of these options will result in better quality care, and all are likely to diminish job satisfaction among nurses and the experience of care among residents.

Moreover, the exclusion of LPNs/LVNs from countable HPRD devalues the LPN role and will limit the feasibility of an important career ladder for NAs – advancing to LPN and ultimately to RN titles. Leaping from NA to RN may seem impossible to many aides and the lengthy course of academic study may seem daunting. Progressing to an LPN/LVN role first may seem more manageable and may provide the confidence to pursue an RN degree.

The Proposed Rule's contention, based on the Abt Associates study, that there is no evidence of a relationship between LPN staffing and safety and quality seems counterintuitive and should be reevaluated on a more granular basis. In the context of a shortage of RNs, the use of LPNs supports the administration of medications and other treatments in a timely and accurate manner. This is an element of quality that CMS, consumers, and nursing homes prioritize. Further, the existence of studies that found that LPNs may practice out of scope when RNs are not available does not justify the wholesale exclusion of LPN care from the count of nurse hours. The Proposed Rule should not be based

on a blanket assumption that professional standards will be violated. Violations of scope of practice and clinical standards can be enforced through the survey and professional discipline processes.

Instead of excluding LPNs/LVNs from the count of minimum hours, CMS should include LPN/LVN HPRDs in in the RN HPRD (as a "licensed nurse HPRD") as New York State does. At a minimum, CMS should include LPN/LVN HPRDs in the NA HPRD.

VII. LESSONS FROM THE NEW YORK STATE EXPERIENCE

New York State's experience with staffing mandates exemplifies the risks associated with mandating unrealistic and inflexible staffing levels without regard for the availability of staff or funding or the needs of residents. As background, according to the U.S. Bureau of Labor Statistics ("BLS") nationwide data, among the states with the "highest employment level" of RNs, New York State has the second highest hourly median wage, second only to California. [10] Further, BLS data indicate that among the states with the "highest employment level" of LPNs, New York State has the second highest hourly mean wage, second only to California.[11] New York State also has the highest hourly mean wage for NAs, among the states with the "highest employment level" NAs.[12] Despite, or perhaps due to, its comparatively high wages, New York's nursing homes cannot recruit the staff necessary to meet the state or proposed federal staffing requirements.

New York enacted minimum nursing home staffing levels in 2021. The new requirements set a minimum of 1.1 licensed nurse hours per resident day (including *both* RNs and LPNs), a minimum of 2.2 hours of certified nurse aide (CNA) time per resident day, and at least 3.5 combined nursing hours per resident day. Enforcement is based on a review of PBJ data on a quarterly basis.

The state is currently engaged in reviewing data and assessing penalties for the initial compliance period -- the second quarter (Q2) of Calendar Year 2022 – despite a declared statewide disaster emergency due to health care workforce shortages and a determination by the Commissioner of Health that an acute labor supply shortage existed during the compliance period. Although subject to fines of up to $2,000 per day, 75 percent of homes across the state were unable to meet the required levels on a quarterly average basis in Q2 of 2022.[13] If a daily test were imposed, as proposed in the federal rule, nearly all homes in the state would have been out of compliance. Based on our analysis of the most recent PBJ data, the situation remains about the same—74 percent of homes in New York were out of compliance with the state requirements in Q2 2023.

The state staffing standards, like the proposed federal standards, require rigid minimum nurse and aide hours per resident day, regardless of the unique needs of residents in the facility and the professional judgment of clinicians. These one-size-fits-all minimum requirements apply to all nursing homes,

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[10] See U.S. Bureau of Labor Statistics, Occupational Employment and Wages, May 2020-2021 29-1141 Registered Nurses, available at https://www.bls.gov/oes/current/oes291141.htm#st .

11 See U.S. Bureau of Labor Statistics, Occupational Employment and Wages, May 2020-2021 29-2061 Licensed Practical and Licensed Vocational Nurses, available at https://www.bls.gov/oes/current/oes292061.htm#st .

[12] See U.S. Bureau of Labor Statistics, Occupational Employment and Wages, May 2020-2021 31-1131 Nursing Assistants, available at https://www.bls.gov/oes/current/oes311131.htm#st.

[13] LeadingAge NY review of New York nursing home compliance with state staffing requirements based on our analysis of quarterly Payroll Based Journal data accessed at https://data.cms.gov/quality-of-care/payroll-based-journal-daily-nurse-staffing.

regardless of size, location, physical layout. We have observed a number of challenges and unfortunate impacts of the requirements and their implementation in New York that may help inform CMS efforts. These include:

- *Difficult Labor Market Conditions and Lack of Government Support*

In the current labor market, it is especially difficult, if not impossible, for providers to find and hire staff. As noted above, only about one-quarter of providers has been able to meet the state's staffing requirements since they became effective in Q2 of 2022.

Despite a declared statewide health care workforce emergency, the state did not implement any additional initiatives in advance of the mandate to increase the availability of applicants, such as new education and training programs or expanding financial aid for existing programs. Nor did it increase nursing home Medicaid rates to enable payment of higher wages that might assist with recruitment and retention. Although the state appropriated funds to support nursing home staffing in the 2021-22 and 2022-23 state budgets, only a fraction has been distributed in over 2 years since the enactment of the legislation (notably, CMS has not approved the required state plan amendments). Funding and workforce development programs to support compliance with the new mandates should have been made available in advance of the mandates to allow providers to prepare by hiring and training staff.

At the same time, the state has progressively raised the standard minimum wage and enacted a higher minimum wage for home care aides, thereby increasing the competition for personnel who might seek NA jobs in nursing homes. Although nursing homes in New York State have typically paid more than the minimum wage, the gap between NA wages and entry-level wages in less demanding food service, retail and hospitality jobs has narrowed. Unlike employers in those sectors, nursing homes do not have the ability to raise prices or close one day or one shift per week in order to manage workforce challenges. Their revenues are generally limited to government rates, and their services are determined by regulation and the needs of their residents.

Adding to the complexity of compliance with New Yorks's staffing requirements, recently enacted legislation penalizes mandatory overtime for nurses in New York, further impeding the ability of homes to comply with staffing mandates. Some nursing homes are faced with an impossible choice – incur sizeable penalties for violating staffing requirements or face significant fines for mandating overtime in order to meet staffing standards.

- *Self-Imposed Limits on Admissions and Impacts on Access*

Conscientious nursing homes in New York State are limiting admissions, closing units, closing entirely, or selling to providers that are willing to staff at the lean levels covered by Medicaid rates notwithstanding the potential penalties. The result is 5,600 more empty nursing home beds today than in 2019, despite waiting lists for many quality facilities and unmet demand from hospitals for discharge destinations.

As full implementation of the state mandates became effective in April 2022, our informal poll of nursing home members found that 41 percent would be restricting admissions further (on top of already closed units and limited admissions due to staff shortages). Lack of nursing home capacity has created back-ups in hospital discharges in many regions of the state, leading to over-crowded

emergency rooms and diversion of ambulances. Consumers seeking quality nursing home care in close proximity to loved ones cannot find an open bed and must accept care from distant or less desirable homes.

Reductions in occupancy in response to staffing mandates are deepening facilities' financial distress. Low census, in addition to rising costs and stagnant rates, is making it extremely difficult to provide the type of wage increases required to recruit and retain staff or pay agency fees that exceed $100 per hour for RNs and $50 per hour for aides.

- *Impacts on Resident-Centered Staffing Models*

New York's experience with minimum hours requirements demonstrates the risks of staffing requirements that are not tailored to resident needs. For example, several LeadingAge NY members face potential state penalties in the first compliance quarter, even though they exceeded the overall hours requirement and exceeded the required nurse hours, because they provided less than the specified sub-requirement of NA hours. Given financial constraints, these facilities may have to lay off nurses in order to hire more CNAs, despite their earlier determination that the clinical needs of their residents demanded more nurse time. If they have concerns about serving a medically-complex population with fewer nurses and more aides, they may be forced to limit admissions of individuals with conditions requiring higher levels of nursing and medical care.

Other facilities have dedicated dementia units with vibrant social activities and robust companion-type staffing. Their residents do not require extensive assistance with dressing, eating, or transferring, but do need a high degree of monitoring and social engagement. Their activities staff and unit aides are not certified NAs and often do not have an interest in pursuing NA certification. These dedicated staff do not count toward the facilities' staffing requirements, under the state law or the Proposed Rule. Depending on New York's assessment of penalties for the first compliance period, which are currently under review, these facilities may face the prospect of laying off non-certified staff in order to hire NAs, often at a higher cost, and often to the detriment of quality of life.

- *Impacts on the Viability of the Not-for-Profit and Government-Sponsored Nursing Home Sector*

We fear that going forward with the Proposed Rule will exacerbate the financial stress that not-for-profit and public homes currently face, threatening access to quality care. In New York, non-profit and public homes are the most financially vulnerable, in large part because they have maintained higher than average staffing and have paid higher than average wages in a reimbursement environment that is blind to that spending. It will be these very facilities that will be at greatest risk of closure or sale to for-profit entities, as a result of the increased financial pressures from this proposal. Since the start of the pandemic, ten nursing homes have closed in New York State (all but one were not-for-profit).

The continuing statewide (and nationwide) staffing crisis demands substantial increases in pay to improve the availability of staff, and drives worrisome revenue losses due to closed units and restricted admissions when workers are not available. Absorbing these financial blows has been extraordinarily challenging to not-for-profit and public nursing homes, given New York's outdated Medicaid operating rates.

- *Impacts of Onerous Penalty Mitigation Application Process*

New York State's staffing regulations allow nursing homes that were unable to comply with staffing mandates to seek mitigation of penalties based on extraordinary circumstances, a declared acute labor supply shortage, and/or a verified union dispute. When New York initiated its enforcement of its staffing mandates this summer based on staffing levels in Q2 of 2022, it received requests for mitigation from 63 percent of the nursing homes in the state. The process of seeking mitigation required facilities to submit extensive documentation of 18 different measures to recruit and retain staff and of efforts to maintain resident health and safety. Facilities reported submitting hundreds of pages of documents and spending dozens of hours to complete the application and to track down and submit the requested documents related to actions taken over a year earlier (e.g., print and digital advertisements; contracts with training programs, job fair vendors and digital platforms; publicity about bonuses; staffing agency contracts; etc.). Busy nursing home leaders were diverted from the important and demanding work of delivering care to residents, in order to file mitigation requests. The value of this overwhelming array of documentation is difficult to discern, as is how it will lead to consistent and objective decisions on penalties.

The existence of this mitigation process did not enable facilities to strike a balance between staffing and access to care, as CMS intends for its exemption and waiver processes. Facilities do not know at the time that they are making admissions decisions whether they will be granted mitigation. They must assume that if they are not in compliance, they will be penalized as indicated in the regulations and limit occupancy accordingly.

In addition to the risks and challenges presented by New York's experience with numerical staffing mandates, we would like to point out that stacking different federal staffing standards on top of the state's requirements will create an administratively difficult and complex system for providers (and regulators) to navigate.

VIII. CMS QUESTIONS NOT ADDRESSED ABOVE

- **Implementation Timeframes:**

While the Proposed Rule's compliance dates are intended to provide lead time for implementation and recognize the special challenges rural areas face, the bottom line is that unless there is a concerted and successful public and private effort to build the workforce, no amount of lead time will suffice. There is little evidence that the staffing crisis is improving, nor that educational and training capacity issues are being sufficiently or rapidly addressed to yield a positive impact within the timeframe required. In fact, the rates of compliance with minimum staffing standards in New York State suggest that staffing shortages are persisting.

At a minimum, all nursing homes should have 3 years to comply with a 24/7 RN requirement and 5 years to comply with HPRD requirements, in both urban and rural areas, after CMS has determined that there are enough qualified applicants, and there are structures for ensuring the continuing supply of future candidates. In addition, there must be appropriate funding to cover the true costs of the additional staff prior to imposing new requirements that mandate their deployment.

- **Structure of Staffing Standards:**

Any staffing requirements should be feasible and flexible enough to permit different models of care, support diverse resident needs, and incorporate the variety of staff that may be involved in providing care to residents. They should also be sufficiently adaptable to facilitate or encourage new and innovative approaches to care. Further, federal staffing standards should allow for the exercise of reasonable professional judgment by medical directors, administrators, and directors of nursing, with input from other staff and residents, based on the knowledge, skills, and experience of the staff available. The Proposed Rule does not fit these criteria.

An aggregate HPRD level would meet these goals better than title-specific requirements, provided that the aggregate HPRD requirement includes the diverse array of direct care staff that promote high-quality care, and the requirement is feasible. We do not, however, support the 3.48 HPRD total nurse staffing standard that CMS suggests. It appears that the suggested 3.48 HPRD would include only nursing staff, which would be infeasible under current workforce and reimbursement conditions. If CMS were to implement an aggregate HPRD requirement, it should include not only RNs and NA, but also LPNs/LVNs and other direct care staff, such as rehabilitation therapy and respiratory therapy staff, feeding assistants, activities staff, medical staff, and social work staff.

CMS has asked whether Directors of Nursing should be counted towards the 24/7 RN coverage requirements and whether the hours of nurses with administrative duties should be included in meeting HPRD staffing standard. Nurses with administrative duties are integral to ensuring appropriate direct care staffing levels. Among our members, nursing leaders and executives frequently assume direct care roles, including nurse aide roles, as resident needs demand. Importantly, the presence of the DON ensures that an experienced RN is available if the need arises. Moreover, the willingness of DONs and other nurse leaders to pitch in as needed and their reliable presence contribute to staff morale and support retention. It is not always feasible for the DONs and other nurses with administrative duties to clock in and clock out as roles change or to schedule these changes in duties. As a result, their direct care time is not always captured in PBJ data. DONs and nurses with administrative responsibilities should be counted in staffing standards without requiring unnecessary operational hurdles.

- **Increasing Transparency and Addressing Staffing Shortages**

While there are requirements that Medicaid rates be "consistent with efficiency, economy, and quality of care," state Medicaid rates do not appear to be meeting those standards.[14] CMS should provide tools to assist states in determining rate adequacy and provide oversight to ensure that state Medicaid rates are adequate and updated regularly enough to ensure that standard is met. CMS should also require states to disclose the percentage of costs covered by Medicaid rates and the calculations that lead to that determination.

- **Alternative Policies to Enhance Compliance, Safeguard Access, and Minimize Provider Burden**

Policymakers should fundamentally reevaluate the concept of minimum staffing requirements with an eye toward how those requirements support person-centered care. If the goal is to build a sustainable long term care system that delivers high-quality care in home-like settings and respects

[14] *See* MACPAC Report, *supra* note 6.

and pays workers competitive wages, inflexible staffing requirements are likely not helpful. Rather than mandating title-specific staffing ratios, the focus should be on ensuring appropriate funding (both Medicare and Medicaid) to enable homes to pay competitive wages and on building the long-term care workforce through expanded support for education and training. These initiatives could be supplemented by targeted reviews of facilities with a pattern of low staffing or staffing-related quality problems.

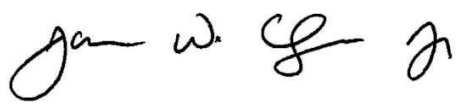
CONCLUSION

Despite facing one challenge after another, New York State's public and non-profit providers remain dedicated and committed to their mission of providing the highest quality of care and the best quality of life to the residents they serve. Penalizing these providers for failure to meet infeasible mandates, due to circumstances beyond their control, is not only unfair, it is also counterproductive. It is doubly unfair when the state and federal governments have the ability to mitigate the barriers to compliance, and they have not taken the steps to do so.

Our dedicated members and our association look forward to working with CMS to pursue our mutual goals of providing high-quality, person-centered care to nursing home residents and building the long-term care workforce. The Proposed Rule is not an effective strategy for achieving these outcomes.

Thank you for your work and for the opportunity to provide input into the Proposed Rule. If you have any questions, please contact me.

Sincerely,



James W. Clyne, Jr.
President and CEO